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A PLAN FOR PROVIDING BASIC MINIMUM HEALTH SERVICES TO EVERYONE

A comprehensive plan for the extension of minimum public health services to the people in every section of the United States is presented in the report of the Committee on Local Health Units of the American Public Health Association entitled, *Local Health Units for the Nation*. Published by The Commonwealth Fund, the report can be obtained for \$1.25 and should be in the library of every person professionally engaged in public health work and of every citizen who is seriously interested in seeing that the public health in his community and State is adequately protected.

PURPOSES AND SCOPE

In the foreword to the report, the committee of which Dr. Haven Emerson is chairman, states the purposes and scope of the study:

"This report, by a committee of State and local public health administrators, is addressed to the home-town folks of continental United States and more particularly to their elected officers of local government of village, town, city, or county. Its purpose is to suggest a way to cover a free society with full time health services at the community level.

"It may come as a shock to many that only two-thirds of the people of our country are today under the umbrella of full-time local health protection, while approximately forty million are excluded by horse-and-buggy political boundary lines, or by the economic stringencies of the areas in which they happen to live. Yet such is our present situation. Further, the provision of health services, whether full or part time, is now essayed by 18,000 or more counties, cities, towns, villages, or districts. These local health jurisdictions are inherited from the past. They came into being, like many good and bad things in a young and growing country, without benefit of policy. We know now that we can afford nothing less than coverage of every population and area unit of our Nation with competent local health

service. How can we achieve it? Do we continue in an outworn tradition, or shall we boldly redesign our apparatus? The authors of this report propose the latter course.

"They begin by presenting a picture of contemporary local health services as they are—the broad features of their adequacies and inadequacies, the number and kinds of persons who do the work, and the cost of this indispensable function of local government. The organization of local health services of each State is considered in detail and the existing personnel and the costs are analyzed. Detailed data are shown in tabular form, making comparative study simple. Comparisons are revealing: for example, it is by no means always true that the richest States spend the largest amount per capita for local health service or have the largest proportion of their population served by full-time local health officers. Other cherished beliefs are upset by examination of State summaries in relation to national figures distributed over the total population. This section of the report stands wholly on factual ground. This is how we are.

"The committee then moves into the realm of attainable possibilities. It suggests a new design in the administrative apparatus for delivering local health services. Employing the same set of guides for each State—

"complete coverage with basic minimum full time service; units of jurisdiction of populations large enough (50,000 or more) to support and justify staffs of full time, professionally trained persons; a cost of approximately \$1.00 per capita—

it shows that all the objectives can be realized and that only about 1,200 units of local jurisdiction would be required to do the job. The authors repeat that this is a way to cover the entire population with full-time basic minimum local health service. The particular proposal for any given State or city-county or multi-county unit, however, must be considered by the people and their local government, and by the respective State health officer or board of health, as expressing a principle of

administration not a finality for action. Another arrangement of counties and populations may be preferable. The principle of local cooperation, however, and the pooling of community resources for health in the interest of economy and efficiency are important, and resemble those that have brought about consolidated or union school districts and road districts serving large areas with engineering adequacy."

CALIFORNIA RECOMMENDATIONS

Thirty-one local health units are recommended for California, serving the entire population in all of the 58 counties. At present, California has 42 local health departments served by a health officer and staff working on a full time basis, but only 29 counties have full-time health departments, the others being in cities. Most of the cities and towns in counties having full time health departments contract with the county for public health service and thus enjoy its benefits.

The geographical distribution of the 31 proposed local units is the same as was suggested by the Division of Local Health Service in the *Thirty-seventh Report of the California State Department of Public Health, July 1, 1940 to June 30, 1943*, as follows:

<i>Unit 1</i>	<i>Unit 7</i>	<i>Unit 14</i>	<i>Unit 22</i>
Del Norte	Marin	Alameda	Alpine
Humboldt	Sonoma		Inyo
			Mono
<i>Unit 2</i>	<i>Unit 8</i>	<i>Unit 15</i>	<i>Unit 23</i>
Lassen	Napa	San Mateo	San Luis Obispo
Modoc	Solano		
Shasta		<i>Unit 16</i>	<i>Unit 24</i>
Niskiyou		Santa Clara	Kern
Trinity	<i>Unit 9</i>	Santa Cruz	
	Sacramento		<i>Unit 25</i>
<i>Unit 3</i>	<i>Unit 10</i>	<i>Unit 17</i>	Santa Barbara
Lake	Amador	Stanislaus	
Mendocino	Calaveras		<i>Unit 26</i>
	El Dorado	<i>Unit 18</i>	Ventura
<i>Unit 4</i>	Nevada	Mariposa	
Butte	Placer	Merced	<i>Unit 27</i>
Glenn	Sierra		Los Angeles
Plumas	Tuolumne	<i>Unit 19</i>	
Tehama		Fresno	
		Madera	San Bernardino
<i>Unit 5</i>	<i>Unit 11</i>		<i>Unit 29</i>
Sutter	San Joaquin	<i>Unit 20</i>	Orange
Yuba		Monterey	
	<i>Unit 12</i>	<i>Unit 30</i>	
	Contra Costa	San Benito	Riverside
<i>Unit 6</i>		<i>Unit 21</i>	
Colusa	<i>Unit 13</i>	Kings	<i>Unit 31</i>
Yolo	San Francisco	Tulare	Imperial
			San Diego

Cost of providing a minimum public health service in the 31 units is estimated at about \$1 per capita per year. Cost of local health service in 1942 was found to be \$0.94, but ranged from \$0.04 in the area covered by the proposed Unit 4 to \$1.61 in the area covered by the proposed Unit 13. In 1942, the people living in 24 of the areas covered by the 31 units were spending less than \$1 per capita and in four areas, those covered by Units 3, 4, 18 and 22, less than 10 cents per capita was

being spent on public health. In seven areas, the people, apparently desiring more than minimum public health protection, were spending more than \$1 per capita. These are the areas covered by Units 9, 13, 15, 23, 24, 25 and 27.

Recommendations are made for personnel and budget in each of the proposed 31 units. While State and local public health administrators, being more familiar than the committee with local problems, may disagree as to detail with the report, it will serve as a most valuable yardstick against which to measure present resources and plans for further progress.

SUMMARY OF FINDINGS

The summary of the findings and recommendations of the committee for the Nation and for California is quoted below:

- “1. The delivery of the half-dozen essential, primary services of public health should be a function of local government responsive intimately and personally to the needs of each community. These services are: (a) vital statistics; (b) communicable disease control; (c) environmental sanitation; (d) public health laboratory services; (e) hygiene of maternity, infancy, and childhood; (f) health education.
- “2. One-third of the Nation lives under sub-standard local health organization ill-equipped to give basic minimum health protection at all times and to meet public health emergencies quickly and efficiently.
- “3. Approximately 20,000 local governmental units, in addition to some 70,000 school boards, are currently responsible for local health service in the United States.
- “4. The failure of local government in some States to organize workable administrative units of local health service is gradually removing the intimate and personal service of local health protection from the sphere of local to that of State government.
- “5. In order to provide the organization of workable administrative units of local health jurisdiction each State should have enabling legislation, either permissive or preferably mandatory, whereby cities and counties may unite to form districts of suitable size for local health administration. Except for special reasons these districts should be made up of existing or combinations of existing governmental units in order that existing tax and appropriate machinery may be utilized.
- “6. For approximately \$1 per capita every person in the United States could have minimum basic local health services under a professionally trained full-time medical health officer, with appropriate associated professional and technical personnel and equipment.
- “7. This country-wide coverage could be achieved through 1,200 local health units.

"8. Essential characteristics of these units are:

- Population of at least 50,000. Smaller populations can only in rare instances either support or justify an adequate local health organization.
- Include no unit of local government below the county (except in certain states where the county is unimportant as an administrative subdivision of government).
- Include both the urban and rural areas of a county.
- Where counties have smaller populations than 50,000, as is true of 85 per cent of the 3,070 counties of the 48 States, they should join with one or more neighboring counties to form local health districts following natural trade and transportation areas.

"9. The minimum staff required by such a local health unit is:

- One full-time medically trained administrative health officer.
- One public health nurse per 5,000 population, one of each ten of the nurses to be of supervisory grade.
- Two workers in environmental sanitation per 50,000 population, one to be professionally trained, preferably as a sanitary engineer.
- One clerk per 15,000 population.
- Part-time clinicians and dentists, and laboratory workers, dental hygienists, health educators, and other workers as local conditions require.

"10. To staff the 1,200 units the following workers are recommended as a minimum:

2,060 full-time administrative health officers and directors of medical divisions. No part-time health officers are recommended.

6,145 local practicing physicians for part-time clinical service.

26,400 public health nurses, nearly twice as many as were reported employed by local official agencies in 1942.

5,800 workers in environmental sanitation of whom one-third should be professionally trained. Only 10 per cent of those employed in 1942 were so trained.

8,930 clerical and secretarial workers including those with statistical training and representing an increase of two-thirds over the number employed in 1942.

3,535 laboratory workers—12 per cent professional, and 44 per cent each technical and unskilled to serve 766 units, the remainder to be served by the State laboratories. In all units of less than 100,000 population both professional supervision and assistance in the more complicated diagnostic procedures will be given by the State laboratory.

3,790 dentists—12 per cent on a full-time basis and 4,265 dental hygienists to carry on a public health dental program in the schools and the general community, a program with notable exceptions, generally lacking in 1942.

540 health education specialists in the most populous 261 units with 60 per cent of the Nation's population. In 1942 only 44 were reported employed and were confined to 12 States.

2,390 messengers, maintenance workers, laborers, and other unskilled workers.

"10a. To staff the 31 units suggested for California, the following workers are recommended as a minimum:

90 full-time administrative health officers and directors of medical divisions. This number is substantially lower than the number reported employed in 1942 when many areas had far better than a minimum service.

192 local practicing physicians for part-time clinical service.

1,378 public health nurses, representing an increase of more than 50 per cent over the number reported employed by local official agencies in 1942.

305 workers in environmental sanitation of whom about one-fourth should be professionally trained. The 604 reported employed in 1942 included only 5 per cent who were either engineers or veterinarians.

456 clerical and secretarial workers including 34 with statistical training and representing only a slight increase over the 1942 reported total employed.

239 laboratory workers—about one-sixth professional and about 42 per cent each technical and unskilled to serve all but the least populous two units.

176 dentists—18 per cent on a full time basis and 169 dental hygienists.

35 health education specialists, seven times the reported 1942 number and designed to serve each unit except the least populous eight.

81 messengers, maintenance workers, laborers and other unskilled workers."

The frequency of absences from work for eight days or longer, due to sickness, exceeded slightly in 1944 the relatively high rates recorded in 1943. The 1944 male rate for all causes was 140.9 per 1,000, and the female rate was 221. The male rate was 37 per cent, and the female rate was 35 per cent higher than the 10 year mean (1935-1944).—Industrial Hygiene News Letter, July, 1945, U. S. Public Health Service.

HEALTH DEPARTMENTS AID MILITARY IN CONTROL OF VENEREAL INFECTION

A review of the work done by public health departments in cooperation with the military to control venereal diseases in California during World War II reveals impressive accomplishments.

Two main problems are involved: the physical rehabilitation of selectees who had syphilis and the protection of service personnel from civilian sources of infection.

From the time the Selective Service Act was passed in November, 1940, civilian health departments in California assumed the responsibility of finding and placing under treatment selectees with syphilis.

Laboratory reports of positive or doubtful serology on selectees are forwarded to the Central Registry of the State Bureau of Venereal Diseases. These reports are routed to local health departments which undertake the task of locating the men.

From November, 1940 through July, 1945, 44,119 investigations of selectees with positive or doubtful serology were initiated in this manner and 90 per cent of the investigations were completed.

Of the 39,816 investigations which were completed, 65 per cent (26,030) selectees were located and examined. Ninety-three per cent (24,209) were discovered to have syphilis.

Only 14 per cent (5,465) of the investigations were returned because the individual had not been located. The remaining 21 per cent (8,321) were completed as having "moved from jurisdiction," "been inducted," "died" and similar reasons.

Results of investigations are reported to draft boards. With this information boards are able to avoid drafting men who have late complications which would make them unfit for military service, and there is averted the time and expense of sending through an induction station men who would be later rejected. Many men are informed of their infection in time to receive adequate treatment before being inducted and the need for their treatment in the Army is thus eliminated.

The protection of service personnel stationed in California from civilian sources of infection presented another problem. Control of venereal diseases among service men and women through education, prophylaxis and the finding and treating of infected personnel is the responsibility of the military medical corps. However, military agencies have found it helpful to utilize the case-finding facilities of civilian health departments.

Service men and women with venereal diseases are questioned as to possible sources and contacts of their infections. Reports of information obtained through these interviews are sent to public health departments

which attempt to find the persons suspected of being the sources of infection or of having been in contact with an infected case.

Between January 1, 1943 and July 31, 1945, 56,588 contacts of military personnel were reported to public health departments in California and investigation on 94 per cent of these were completed.

Of the 53,215 investigations which have been completed, 31 per cent (16,664) of the suspects were located and examined. Of these, 57 per cent (9,389) were found to be infected and were placed under treatment. Location of contacts was made difficult because, in many instances, reliable information can not be obtained from the patient due to intoxication at the time the infection was acquired, and other factors.

From the beginning of the war emergency, public health departments have assisted law enforcement agencies by providing them with addresses named by military personnel as the places where sources of infection were encountered and the places where exposure to infection took place.

OIL DERMATITIS

A number of cases of dermatitis due to exposure to a light oil used as a coolant in a plant engaged in grinding magnesium to powder were recently investigated by the Bureau of Adult Health. Magnesium ingots are ground in a bath of the oil and in handling the metal the oil came in contact with the skin. Gloves and impervious aprons used in the plant were inadequate protection.

The following recommendations were made to the management: (1) Procure synthetic rubber gloves with longer cuffs and weave sleevelets of the same material to prevent the oil from getting inside the gloves; (2) establish a rigid washing routine schedule for workers to clean off the oil that does get onto the skin; (3) secure sulfonated oil cleanser containing corn meal as abrasive; (4) have work clothes cleaned at least twice weekly.

Among white female policyholders (ages 1 to 17), of the Metropolitan Life Insurance Company, the death rate from cancer, adjusted to discount the effect of the aging of the group, has been quite generally downward for about a third of a century. Among insured white males, the mortality from cancer, until very recently, had been increasing, although at a diminishing rate; but in the past few years it has also tended downward.—Statistical Bulletin, July, 1945, Metropolitan Life Insurance Company.

COOPERATIVE PROGRAM FOR CONTROL OF BRUCELLOSIS IN CATTLE

A cooperative Federal-State voluntary program for the control of brucellosis in cattle is announced by the Division of Animal Industry of the State Department of Agriculture. The program consists of the vaccination of calves with strain 19 vaccine, and, where indicated, agglutination tests of mature cattle.

The vaccine to be used will be tested in the laboratory of the State Department of Public Health to determine that it meets required standards.

The vaccination of calves and the taking of blood samples will be conducted by accredited practicing veterinarians who will be employed by the owners. Agglutination tests will be performed in the laboratory of the Division of Animal Industry.

It is expected that in most herds infected with brucellosis, the gradual elimination of the disease will be accomplished by replacements with vaccinated young stock. When calf vaccination has progressed sufficiently to justify blood testing, the owner may have the mature cattle tested.

When a herd has passed two successive satisfactory tests at least six months apart, it will be designated as a Federal-State brucellosis free certified herd. Certificates will be issued which will be valid for one year.

The control of brucellosis in cattle ultimately should result in a decrease in human infections, which have been increasing steadily in California and in 1944 reached a peak of 320 cases with five deaths.

In the issue of *California's Health* for July 15, 1944, there was published a report on the history, mode of spread and geographical distribution of brucellosis in California, written by Dr. Harlin L. Wynnns. Among the striking facts brought out in the article is the estimate that 63 per cent of cases reported are probably acquired through drinking raw milk or cream or eating food made of raw milk, while 18 per cent possibly were acquired through handling infected stock and raw meat.

Highest rates during the five-year period, 1939-43, were in rural counties where pasteurized milk and cream is not generally available and where a large proportion of the public is exposed in their work to brucellosis. Highest case rate during the period was in Colusa County (30.84) and lowest was in San Francisco (0.50), which has required during the past 12 years that all fluid milk sold in the city and county be pasteurized.

With a tuberculosis death rate of 45.7 per 100,000 population, California in 1943 was 13th among the States. The National death rate was 42.6.

OTHER FOODS CAN SUBSTITUTE FOR EGGS IN INFANTS' DIETS

Lack of iron in the infant's diet due to the shortage of eggs in some areas in the State can be remedied by substituting for egg yolk other iron-rich foods.

The Bureau of Maternal and Child Health has issued a leaflet recommending the following substitutions which are suitable for infant feeding and will supply significant amounts of iron to the daily diet:

Dark Karo syrup

Molasses (Contains twice as much iron as dark Karo syrup. White sugar contains no iron)

Whole grain cereals

Cream of Wheat (Enriched)

Pablum and Pabena

Vegetables, such as green beans, peas, puree of dry cooked beans and lentils, greens, carrots

Meat, especially liver and heart. (Pork liver contains five to six times more iron than calf and beef liver)

A full-term baby born of a well nourished mother has a body store of iron at birth which usually lasts through the first three or four months of life. The iron needs of an infant under one year of age are estimated at 6 mg. daily. This need is met in the early months of life from the reserve present at birth. Later it must be supplied by foods of which egg yolk is the most dependable.

NEW STANISLAUS COUNTY HEALTH OFFICER

Dr. George F. O'Brien has been appointed Health Officer of Stanislaus County to replace Dr. J. Lyle Spelmann, resigned. Dr. O'Brien formerly was Health Officer of Solano County and Venereal Disease Control Officer of the City of Sacramento. More recently he has been engaged in private practice in Sacramento and with Permanente Foundation in Oakland.

BIRTHS INCREASE; DEATHS DECREASE

The number of births continued to increase in California during the first five months of 1945.

Estimated births for January through May were 72,927 as compared with 68,597 during the same period in 1944 and with the five-year median of 68,597.

The total number of deaths dropped slightly to 38,976 during the first five months of 1945 as compared with 39,667 during the same period in 1944. The five-year median is 38,236.

From January through May, 1945, there were declines in the rates for infant mortality (34.0), neonatal mortality (22.7), and maternal mortality (1.8) as compared with the same period in 1944.

MAJORITY OF THE STATES HAVE PRE-MARITAL AND PRENATAL LAWS

Thirty-two States and the Territory of Hawaii now require premarital examinations for syphilis of both bride and groom and 35 States and the Territory of Hawaii require prenatal examinations for syphilis.

Florida, Oklahoma and Hawaii adopted premarital legislation during 1945 sessions of legislatures. Prenatal laws were passed in Arizona, Florida, Montana, Ohio and West Virginia.

In California, marriage clerks may accept medical certificates on the official forms issued by other States having premarital laws comparable to the one in California. They are the following States:

Colorado	North Carolina
Connecticut	North Dakota
Florida	Ohio
Idaho	Oklahoma
Illinois	Oregon
Indiana	Pennsylvania
Iowa	Rhode Island
Kentucky	South Dakota
Maine	Tennessee
Massachusetts	Utah
Michigan	Virginia
Missouri	Vermont
Nebraska	West Virginia
New Hampshire	Wisconsin
New Jersey	Wyoming
New York	

TRAILER COACH ACT CONSTITUTIONAL

Section 18600.5 regulating trailer coaches during the emergency, added to the Health and Safety Code by Chapter 404, Statutes of 1945 has been declared constitutional by the Attorney General in an opinion prepared for the Chief of the Division of Immigration and Housing.

The section provides that, except in counties having a population in excess of 900,000, every trailer coach parked in a trailer camp shall comply with all of the requirements pertaining to buildings in an auto court under any of the following circumstances:

(a) Where the trailer coach has been rigidly attached to or connected with water, gas or sewer pipes.

(b) Where the trailer coach has been permanently attached to the ground by means of underpinning or foundation.

(c) Where the trailer coach has been altered or changed in such a manner that it fails to comply with the requirements of the Vehicle Code governing the use of trailers on public thoroughfares.

(d) Where the trailer coach does not carry a current yearly license issued by a State Motor Vehicle Department."

In commenting upon the fact that an exception is made of Los Angeles County, the Attorney General's office makes this observation:

"The legislation is certainly valid as a war emergency measure. The emergency advantage must be weighed against the general advantage to health and safety. Under the emergency housing conditions brought about by the war, it is reasonable to suppose that certain health and safety measures could be lifted without undue jeopardy to health in less populated areas and that such health and safety measures could not be lifted in the more thickly populated areas, even for the meritorious purpose of increasing the number of housing units."

WELFARE DEPARTMENT STANDARDS

A mimeographed book, "Standards for Parent-Child Homes" has been issued by the State Department of Social Welfare. In addition to the recently revised regulations of the Social Welfare Board, the book contains excerpts of the Welfare and Institutions Code pertaining to parent-child homes, information on the supervision and general care of children, including health supervision, and a reading list on such subjects as child health and development, nutrition and recreation.

EXPANDED MCH SERVICES PROPOSED

A 10-year program of expanded maternal and child health is proposed in a bill, S. 1318, introduced into the United States Senate by Senator Claude Pepper and nine other Senators.

The bill, which authorizes an appropriation of \$100,000,000 for the first year would provide complete maternity care, including prenatal and postnatal service, to all mothers "who elect to participate in the benefits of the program."

It would also provide preventive, curative and corrective services for children in the home, clinic and school, and would expand medical programs for crippled and other physically handicapped children as well as welfare programs designed to curb child delinquency. The Federal administrative agency would be the Children's Bureau of the United States Department of Labor.

Of 7,000 infants born each day in the United States, about 270, or 1 in 26, eventually become incapacitated by abnormalities of the mind.—Commander Francis I. Braceland, U. S. N. In testimony before the U. S. Senate Subcommittee on Wartime Health and Education.

CADET NURSES TAKE SIX MONTHS TRAINING IN PUBLIC HEALTH AGENCIES

Nineteen senior cadet nurses are receiving the last six months of their training in public health agencies in California and inquiries received by the Bureau of Public Health Nursing indicate that there is an increasing interest among student nurses to enter the public health field.

After October 15th the United States Cadet Nurse Corps will no longer receive applicants. Student nurses already enrolled in the corps will continue as cadets until completion of their nursing school programs.

Under the accelerated program of many nursing schools, a Cadet Nurse is able to complete all courses required for graduation and still have time to spend six months of training in the field of nursing she wishes to enter upon graduation. This period may be spent in Federal nursing services, in public health agencies or in specialized or general civilian hospitals.

Institutions and agencies offering senior cadet experience must be approved by the State Board of Nurse Examiners. Public health agencies in California which have been approved are: the health departments of Berkeley, Los Angeles County, Oakland, San Luis Obispo County, Sutter-Yuba Bi-County Health District and Vallejo-Solano County Health Department; the American Red Cross Visiting Nurse Service in San Mateo County and the San Francisco Visiting Nurse Association.

Under the United States Cadet Nurse program, the students must be provided with a stipend of \$30 a month plus maintenance. In cases where public health agencies are unable to provide the stipend and maintenance, the California State Department of Public Health is able to assist by providing training funds.

SANITATION SURVEY

The most comprehensive survey yet undertaken of postwar sanitation needs in California is being made by the United States Public Health Service in cooperation with the Bureau of Sanitary Engineering.

Under the direction of Lt. Col. A. L. Dopmeyer, Senior Sanitary Engineer, USPHS, field engineers are securing information concerning needs and plans for water supplies, sewerage systems, garbage and refuse disposal in 500 communities in the State.

Part of a National survey, the information obtained in California will be made available locally through the Bureau of Sanitary Engineering and will be helpful in State as well as in National planning.

ADVOCATES BORIC ACID BE REMOVED FROM USE

Boric acid, which when mistaken for dextrose, sterile water or other fluids and fed to infants has caused several deaths, should be removed from use entirely according to E. H. Watson, M.D., writing in the September 29th issue of *The Journal of the American Medical Association*.

Dr. Watson who is connected with the University of Michigan Medical School reports that boric acid preparations were removed from use in the children's ward of University Hospital several years ago and states:

"Probably the principal uses of boric acid or its solutions are in the eye and for irrigating body cavities. Both of these uses have been abandoned in the University Hospital. Boric acid solution as ordinarily used in eye wash is probably without significant antiseptic or germicidal properties—many newer antiseptics are far superior to it. As a lavage to remove pus from the eye a weak solution of sodium bicarbonate is much more effective.

"Boric acid is so frequently used as a household article that its power for harm is ordinarily overlooked. Yet its potential danger is such that its use as a food preservative has long been forbidden in the United States, France, Germany, Holland, Italy and Spain."

MEDICAL OFFICER EMPLOYED FOR PHYSICAL REHABILITATION PROGRAM

Martin Karr, M.D., has been employed as Medical Officer in the Bureau of Maternal and Child Health and assigned to the Bureau of Vocational Rehabilitation, Department of Education, where he will give assistance in developing the new physical restoration program of that agency along the lines of the medical care programs of the Department of Public Health.

Dr. Karr formerly was in practice in Sonora and in San Mateo, and more recently was a member of the United States Army Medical Corps.

COMMITTEE ON TUBERCULOSIS REGULATIONS

A committee of specialists has been appointed to make recommendations to the State Board of Public Health for changes in the regulations governing the State tuberculosis subsidy. The committee is composed of Dr. Howard W. Bosworth, chairman, Dr. Chesley Bush and Dr. Leo Tepper. They will be assisted by the two official advisors to the Bureau of Tuberculosis, Dr. Francis M. Pottenger, Sr., and Dr. Edward Kupka.

TWO YEARS OF EMIC

Authorization for medical and hospital care of wives and infants of service men issued in California during the first two years' operation of the Emergency Maternity and Infant Care program totals 62,689.

From July, 1943, through June, 1945, the Bureau of Maternal and Child Health issued 59,823 authorizations for prenatal, delivery and post-partum care and 3,866 authorizations for care of sick infants.

A total of \$4,268,826.59 was spent in the program during the biennium, of which over \$3,000,000 was spent in the second year. More than 35,000 physicians and 300 hospitals are participating.

New cases will be admitted to the Emergency and Maternity and Infant Care program up to six months after the war emergency is declared at an end.

MORBIDITY REPORTS—SELECTED DISEASES—
CIVILIAN CASESTOTAL CASES FOR JULY AND TOTAL CASES FOR
JANUARY THROUGH JULY 1945, 1944, 1943 and
5 YEAR MEDIAN (1940-1944)

Selected diseases	Current month				Cumulative			
	July				January through July			
	1945	1944	1943	5-yr. median 1940-1944	1945*	1944	1943	5-yr. median 1940-1944
Chickenpox	1,327	1,095	1,483	1,242	38,503	28,248	39,144	28,248
Coccidioidal granuloma								
Conjunctivitis—acute infectious of the newborn (Ophthalmia neonatorum)	1	2	2		24	20	14	
Diarrhea of the newborn	3	1	5		14	22	26	
Diphtheria	70	59	50	56	669	709	603	553
Dysentery, bacillary	18	37	42		165	225	247	
Encephalitis, infectious	28	5	30		53	38	58	
Epilepsy	107	113	113		904	883	1,063	
Food poisoning	39	18	52		294	410	430	
German measles	357	314	540		10,101	13,635	28,113	
Influenza, epidemic	28	27	71	63	523	10,816	1,289	9,501
Jaundice, infectious	10	8	6		142	186	83	
Malaria	7	16	13	16	59	78	77	78
Measles	1,596	2,536	1,211	1,211	29,200	64,087	19,213	19,213
Meningitis (meningococci)	37	67	53	15	475	731	632	120
Mumps	1,501	1,164	1,366	1,366	30,469	25,037	19,281	20,524
Pneumonia, infectious	157	208	242	208	2,342	2,911	2,982	2,244
Poliomyelitis, acute anterior	85	43	473	43	176	183	862	183
Rabies, animal	38	63	56	56	434	590	465	387
Rheumatic fever, acute	57	58	17		465	347	199	
Scarlet fever	487	409	320	259	9,931	6,915	4,308	4,153
Smallpox	1	0	0	0	4	20	4	9
Tuberculosis:								
Pulmonary	625	602	623	674	4,906	4,744	4,559	4,386
Other forms	46	44	42	44	351	276	259	
Typhoid fever	16	16	11	16	54	177	66	122
Typhus fever	1	2	2		18	8	13	
Undulant fever	18	25	13	25	152	172	103	168
Whooping cough	1,014	323	1,100	1,100	10,604	2,796	11,589	9,870
Venereal diseases:								
Chancroid	23	19	8		153	183	108	
Gonococcus infection	2,136	1,609	1,113	1,538	15,271	10,701	7,534	9,775
Granuloma inguinale	2	2	2		28	17	14	
Lymphogranuloma venereum	18	17	19		145	129	86	
Syphilis	2,106	2,142	2,439	2,158	16,577	16,221	18,280	13,412

* Corrections, January-July included.

"We spend fortunes for hospital care of the end products of mental disturbances but only pittances for prevention. Blindly and foolishly we continue to pay \$210,000,000 a year of public funds to maintain our mentally ill in hospitals, but only about \$5,000,000 for the support of mental hygiene clinics to prevent their commitment."—Dr. Victor H. Vogel quoted in "Beacon," published by the Mental Hygiene Society of Northern California.

MORBIDITY REPORT—JULY, 1945

Reportable diseases	Week ending				Total cases	5-yr. median	Total cases
	7/7	7/14	7/21	7/28			
Amebiasis (Amoebic Dysentery)	1	3	5	2	11		74
Anthrax	3	2			5		12
Botulism	4	7	5	7	23		133
Chancroid	439	418	268	202	1,327	1,242	38,503
Chickenpox (Varicella)							
Cholera, Asiatic							24
Coccidioidal granuloma							
Conjunctivitis—Acute infectious of the newborn (Ophthalmia neonatorum)					1	1	14
Dengue					1	1	1
Diarrhea of the newborn	15	20	17	18	70	56	669
Diphtheria	11	1	4	2	18		165
Dysentery, bacillary					4	8	53
Encephalitis, infectious					28		
Epilepsy	29	38	16	24	107		909
Food poisoning					26	10	294
German measles (Rubella)	115	94	76	72	357		10,101
Glanders							
Gonococcus infection	445	598	503	590	2,136	1,538	15,271
Granuloma inguinale					2	2	28
Influenza, epidemic	20	5	2	1	28	63	523
Jaundice, infectious	1	2	5	2	10		142
Leprosy	2		1		3		10
Lymphogranuloma venereum (lymphopathia venereum, lymphogranuloma inguinale)					2	4	145
Measles (Rubeola)	521	396	318	369	1,598	1,211	29,200
Meningitis, meningoococcal	8	12	11	6	37	15	475
Mumps (Parotitis)	463	456	325	257	1,501	1,366	30,469
Paratyphoid fever, A and B	1		1		2		13
Plague							
Pneumonia, infectious	42	38	41	36	157	203	2,342
Poliomyelitis, acute anterior	20	20	24	21	85	43	176
Pitressis	1				1		1
Rabies, human	13	14	6	5	38	56	434
Rabies, animal							
Relapsing fever							
Rheumatic fever	11	23	10	13	57		465
Rocky Mountain spotted fever							
Scarlet fever	137	135	115	100	487	259	9,931
Septic sore throat, epidemic							
Smallpox (varola)	1				1	0	4
Syphilis	383	671	420	632	2,106	2,158	16,577
Tetanus	4	1	2	3	10		47
Trachoma							
Trichinosis							9
Tuberculosis, pulmonary	132	118	156	219	625	674	4,906
Tuberculosis, other forms	10	8	12	16	46	44	351
Tularemia					2	1	3
Typhoid fever	5	3	7	16	16	16	54
Typhus fever					1	1	18
Undulant fever (Brucellosis)	5	4	6	3	18	25	152
Whooping cough (Pertussis)	268	254	253	239	1,014	1,100	10,603
Yellow fever							
Totals					11,995		173,418

Note: Military cases, if any, not included.

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